Prior Authorization Review Panel
MCO Policy Submission

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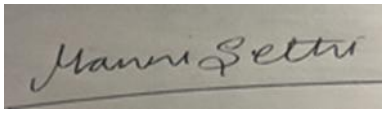
Plan: AmeriHealth Caritas Pennsylvania Community HealthChoices/Keystone First Community HealthChoices	Submission Date: 7/1/2026
Policy Number: CCP.1514	Effective Date: 7/5/2022 Revision Date: 6/1/2026
Policy Name: Skin surgery after massive weight loss	

Type of Submission:

☐ New Policy	☒ Prior Authorization Policy
☒ Revised Policy*	☐ Base Policy
☐ Annual Review- no revisions	☐ Experimental/Investigational Policy
	☐ Statewide PDL
	☐ Other:

*All revisions to the policy must be highlighted using track changes throughout the document.

Please provide any clarifying information for the policy below:

Name of Authorized Individual (Please type or print): Manni Sethi, MD, MBA, CHCQM	Signature of Authorized Individual: 

Keystone First
Community HealthChoices

Skin surgery after massive weight loss

Clinical Policy ID: CCP.1514

Recent review date: 6/2026

Next review date: 10/2027

Policy contains: Body contouring; brachioplasty; massive weight loss; obesity; rhytidectomy; thighplasty.

Keystone First Community HealthChoices has developed clinical policies to assist with making coverage determinations. Keystone First Community HealthChoices' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by Keystone First Community HealthChoices, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Keystone First Community HealthChoices' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Keystone First Community HealthChoices' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Keystone First Community HealthChoices will update its clinical policies as necessary. Keystone First Community HealthChoices' clinical policies are not guarantees of payment.

Coverage policy

Surgical excision of redundant skin of body areas (e.g., brachioplasty and thighplasty) following massive weight loss is clinically proven and, therefore, may be medically necessary when all of the following criteria are met (American Society of Plastic Surgeons, 2017; Mechanick, 2013):

- A plastic surgeon performs the surgical procedure to modify the skin envelope, subcutaneous layer, and/or investing fascia.
- Surgery will correct functional impairment caused by excessive skin and subcutaneous tissue redundancy.
- A functional impairment is defined as a direct and measurable reduction in physical performance of an organ or body part, resulting in difficulties in physical and motor tasks, independent movement, or performing basic life functions.
- There is photographic documentation of any of the following chronic or recurring conditions related to excess tissue and skin folds:
    - Intertrigo (bacterial or fungal infections).
    - Cellulitis.
    - Folliculitis.
    - Skin ulceration.
    - Skin or subcutaneous abscesses.
    - Monilial infection or fungal dermatitis.
    - Skin necrosis.
    - Documentation of failure of at least three months of conservative nonsurgical management by a physician other than the operating physician.

- Maintenance of a stable body weight during the most recent six months or longer.
- If massive weight loss occurs as a result of bariatric surgery, the procedure should not be performed for at least 12 to 18 months after the bariatric surgery.

Note: This policy does not apply to abdominoplasty or panniculectomy.

Limitations

All other indications for excising redundant or excessive skin after massive weight loss are not medically necessary, including, but not limited to:

- Improving cosmesis in the absence of a functional impairment.
- Relieving neck or back pain, as there is no evidence that reduction of redundant skin and tissue results in less spinal stress or improved posture or alignment.
- Repairing a diastasis recti.
- Minimizing the risk of hernia formation or recurrence.

Alternative covered services

- Analgesics.
- Antibiotics.
- Cortisone ointments.
- Drying agents.
- Topically applied skin barriers and supportive garments.

See CCP.1554 for policy on non-cosmetic indications of abdominoplasty.

Background

Obesity and its associated medical morbidities carry substantial health risk. Treatments for obesity, including bariatric surgery and pharmacologic obesity treatment, may result in substantial or massive weight loss. Definitions of massive weight loss vary and include loss of 100 pounds (approximately 45.45 kilograms) or more, 50% or greater loss of excess weight, or loss of an amount greater than 100% of the person's ideal body weight (Constantine, 2014; Michaels, 2011). Complications after bariatric surgery are common, ranging from 23% to 70%, mostly wound-related (Makarawung, 2022).

The emergence of glucagon-like peptide-1 receptor agonist therapy has created an additional population seeking excision of redundant skin after substantial weight loss. Evidence for this population remains less mature than postbariatric evidence, and available data support continued emphasis on durable weight stability, nutritional optimization, and individualized perioperative risk assessment rather than a separate medical-necessity pathway (Garbaccio, 2025; Collaco, 2026).

A sudden change in body mass index can lead to redundant skin and soft tissue with poor tone. Surplus skin and malpositioned adipose deposits result in musculoskeletal strain from increased tissue weight and can cause functional limitation with walking, maintaining adequate hygiene, bowel and bladder habits, and sexual activity, as well as psychological issues associated with poor body image (Giordano, 2015). Bariatric surgery is associated with various metabolic complications and deficiencies that can disturb wound healing and are not typically found in other causes of massive weight loss, such as diet and exercise or post-pregnancy (Giordano, 2015). Reshaping procedures may relieve these symptoms.

The term “body contouring” refers to any surgical procedure used to modify the skin envelope, subcutaneous layer, and/or investing fascia to rid the functional and esthetic impairment from skin after massive weight loss (Giordano, 2015). Several surgical techniques, each with its own modifications, may be used to address the needs of these patients, including (Giordano, 2015):

- Rhytidectomy (face and neck lift)
- Brachioplasty (arm lift) with or without liposuction
- Mastopexy (breast lift) with or without mammoplasty
- Body lift:
- Belt lipectomy (or lower body lift in which the lower body is treated front and back in its entirety)
- Upper body lift that treats excess skin folds in the back
- Thighplasty

Brachioplasty and thighplasty are the principal procedures addressed in the current coverage criteria. Liposuction may be used adjunctively with selected excisional procedures to facilitate contouring and tissue mobilization, but suction-assisted lipectomy alone does not excise redundant skin and should not be treated as a standalone service under this policy (Albanese, 2025; Bishara, 2025).

Skin redundancy and quality, lipodystrophy, and adherent folds, as well as the presence of varicose veins, lymphedema, and overall scar evaluation must be considered with these complex and extensive procedures. The extent of the procedures and the patient’s health and comorbidities will determine the facility setting, the type of anesthesia needed, recovery time, and physician follow-up visits. Patients may be seen intermittently for one to two years as final body contour continues to mature (American Society of Plastic Surgeons, 2017).

Findings

Guidelines

Clinical guidance from the American Society of Plastic Surgeons supports body-contouring surgery for functional impairments caused by excess skin 12 to 18 months after bariatric surgery, once individuals have maintained a stable, near-normal weight for at least two to six months or have reached a body-mass-index range of 25 to 30 kilograms per meter squared (American Society of Plastic Surgeons, 2017).

Emerging evidence on pharmacologic weight loss does not establish separate coverage criteria. In a systematic review and meta-analysis of semaglutide studies, weight loss plateau occurred at approximately 53 weeks, but available discontinuation data showed substantial weight recurrence within 12 to 24 weeks after stopping therapy (Garbaccio, 2025). A separate systematic review and meta-analysis found a possible association between GLP-1 receptor agonist exposure and wound dehiscence, but the finding was attenuated in sensitivity analysis and the included studies had moderate or serious risk of bias (Collaco, 2026). These findings support continued reliance on documented weight stability, nutritional optimization, and individualized perioperative assessment.

Systematic Reviews and Meta-Analyses

High-level syntheses continue to support body-contouring surgery after massive weight loss when redundant skin produces measurable functional impairment, while also confirming material postoperative risk. A systematic review and meta-analysis of 15 nonrandomized studies found that patients undergoing postbariatric body-

contouring surgery had greater improvements in body image, physical function, psychological well-being, sexual health, and social function than patients undergoing bariatric surgery alone (Mokhtar, 2026). Earlier syntheses reported improvements in body image and in physical, psychological, and social functioning after contouring surgery (Jiang, 2021; Toma, 2018; Gilmartin, 2016). Conversely, pooled analyses document notable morbidity, including brachioplasty scarring and re-intervention risk, a 31.5 percent overall complication rate in postbariatric body contouring, and higher complication risk in postbariatric compared with non-bariatric patients (Aljerian, 2022; Marouf, 2021; Hasanbegovic, 2014). These findings strengthen the reconstructive rationale for surgery when functional impairment is documented, but they do not support coverage for cosmesis alone.

Procedure-specific evidence is most relevant for thighplasty and brachioplasty. In medial thighplasty, liposuction-assisted techniques were associated with lower overall complications than non-liposuction approaches, including lower infection, hematoma, and lymphocele/seroma rates, although the evidence was limited by heterogeneous techniques, follow-up, and comorbidity reporting (Albanese, 2025). In brachioplasty after massive weight loss, the literature remains heterogeneous and does not establish a single preferred approach, but liposuction-assisted resection, posteromedial scar placement, and stepwise excision have been proposed to reduce complications and improve scar visibility (Bishara, 2025). These findings support individualized operative planning and do not create a coverage preference for a specific technique.

Adjunctive hemostatic strategies remain investigational for coverage purposes. A systematic review and meta-analysis found tranexamic acid was associated with lower hematoma risk in breast and body-contouring procedures, with no significant difference in seroma formation and limited abdominal-contouring data (Fijany, 2025). Because dosing, route, operative indications, and body regions varied across studies, tranexamic acid use should be discussed as perioperative context rather than as a medical-necessity criterion.

Other Evidence

Observational studies provide additional context on postoperative trajectories and patient well-being. A cohort analysis reported that individuals who underwent body-contouring surgery after bariatric procedures achieved significantly greater reductions in body-mass index, total body-weight loss, and excess-weight loss than propensity-matched controls who did not pursue contouring (ElAbd, 2021). By contrast, a longitudinal survey revealed that patients who desired but did not receive contouring surgery exhibited lower body satisfaction and more depressive symptoms up to five years after their bariatric operation (Buer, 2022).

In 2026, we updated the background and findings sections with recent systematic reviews and meta-analyses on postbariatric patient-reported outcomes, pharmacologic weight loss, GLP-1 receptor agonist perioperative safety, medial thighplasty, brachioplasty, and tranexamic acid; added in-text APA citations using first author last name and year (Albanese, 2025; Bishara, 2025; Collaco, 2026; Fijany, 2025; Garbaccio, 2025; Mokhtar, 2026); updated the reference search date and search terms; added 2025 and 2026 references; and populated the related codes table using grouped CPT code ranges where appropriate. The policy criteria are unchanged.

References

On May 17, 2026, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “Body contouring;” “brachioplasty;” “massive weight loss;” “obesity;” “rhytidectomy;” “thighplasty”. We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

6/2022: initial review date and clinical policy effective date: 7/2022.

6/2023: Policy references updated.

6/2024: Policy references updated.

6/2025: Policy references updated.

6/2026: Policy references updated.

Related codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.1514 This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code description
15825	Rhytidectomy; neck with platysmal tightening
15828-15829	Rhytidectomy; cheek, chin, and neck; superficial musculoaponeurotic system (SMAS) flap
15832-15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad, or other area